

ITEM 36

CENTRAL SAN JOAQUIN VALLEY
RISK MANAGEMENT AUTHORITY

CLAIM FORM
(Please Type Or Print)

received
6/14/07 408

CLAIM AGAINST City of Lemoore (Name of Entity)

Claimant's Name Lois Atwell-Miranda S.S. #: 545-82-2910

Claimant's Date of Birth 02/15/54 Telephone # (559) 925-1354

Claimant's Address 16421 yokut ct Lemoore CA 93245

Address where Notices about Claim are to be sent, if different from above:

Date of Incident/Accident/Arrest: 3-8-07

Date Injuries, Damages or Losses were discovered: 3-8-07

Location of Incident/Accident/Arrest: 18 feet east of Linda Ln (Bush St West)

What did Entity or Employee do to cause this Loss, Damage or Injury?

Unsafe Speed - Section 22350 CVC
Employee did not have enough time to stop and avoid
collision.

(Use Back of this Form or Separate Sheet if necessary to answer this Question in Detail.)

What are the Names of the Entity's Employees who caused this Injury, Damage or Loss (if known)?

Russell Jess Coiran

What specific Injuries, Damages or Losses did Claimant receive? Neck Strain

Vehicle damages - unknown unsafe to drive.

(Use back of this form or separate sheet if necessary to answer this question in detail.)

What amount of money is claimant seeking, or if amount is in excess of \$10,000, which is the appropriate court of jurisdiction. Note: If Superior and Municipal Courts are consolidated, you must represent whether it is a "limited civil case" [see Government Code 910(f)]

Vehicle damage cost is unknown because vehicle is unsafe to
drive to get estimates. Medical Expenses for injury

(Use back of this form or separate sheet if necessary to answer this question in detail.)

How was this amount calculated (please itemize)? \$75000

(Use back of this form or separate sheet if necessary to answer this question in detail.)

Date Signed: 06/04/07 Signature: Lois Atwell

If signed by Representative:

Representative's Name _____

Address _____

Telephone # _____

Relationship to Claimant _____

RECEIVED
AUG 29 2007
AIMS - 92

received
09/14/07

September 12, 2007

City of Lemoore
Attn: Risk/Liability Department
119 Fox Street
Lemoore, CA 93245

Re: Our Claimant: Lois Atwell-Miranda
Date of Birth: 02/15/54
Date of Injury: March 8, 2007
Plan Participant: Lois Atwell-Miranda
Group Name: Tachi Palace Hotel & Casino, #355
Policyholder: Russel Jess Giron

NOTICE OF LIEN

Dear Risk/Liability Department:

We have been advised that your company may provide coverage for Russel Jess Giron who is the responsible party regarding the injuries sustained by Lois Atwell-Miranda in the MVA of March 8, 2007.

HealthComp is the Administrator of medical benefits for the Tachi Palace Hotel & Casino Benefit Plan. This is a **self-insured** plan administrated in accordance with the provisions of **ERISA**, and there is a provision that requires reimbursement of benefits in the event of a responsible third party.

We ask that you reimburse the Plan for benefits issued as a result of this incident. **To date**, we have received claims totaling **\$6,608.77**. Enclosed please find a spread sheet to show the accounting for these claims. Please let this document serve as verification of our reimbursement request.

Please notify us **prior** to settling so we may advise you **then** of our total lien amount. A self-addressed envelope is enclosed for your convenience.

Thank you for assisting our plan participant to carry out the terms of her health plan regarding the third party reimbursement provisions. If you have any questions, please contact our office at (800) 442-7247 Ext. 2403 or fax to (559) 499-2458.

Sincerely,

Bernie Torrejos
Third Party Liability Dept.
HealthComp Administrators

cc: Lois Atwell-Miranda
Acclamation Insurance Management Services (AIMS)

Enclosure



CENTRAL SAN JOAQUIN VALLEY RISK MANAGEMENT AUTHORITY

CLAIM FORM (Please Type Or Print)

CLAIM AGAINST Russell Jess Giron / CSTJVRMA

Claimant's Name Health Comp / Lois Atwell-Miranda S.S.#: 545-82-2910

Claimant's Date of Birth 2/15/54 Telephone #

Claimant's Address 16421 Yokut Ct. 93245 (Lemoore CA)

Address where Notices about Claim are to be sent, if different from above:

Heath Comp Adminstrators, P.O. Box 45018, Fresno CA 93718-5018

Date of Incident/Accident/Arrest: 3/8/07

Date Injuries, Damages or Losses were discovered: 3/8/07

Location of Incident/Accident/Arrest: Bush St. West, East of Linda Ln. (Lemoore, CA)

What did Entity or Employee do to cause this Loss, Damage or Injury?

Per Police Report: "D-2 (Giron) caused this collision by driving V-2 in violation of section 22350 CVC - Unsafe Speed."

(Use back of this form or separate sheet if necessary to answer this question in detail.)

What are the Names of the Entity's Employees who caused this Injury, Damage or Loss (if known)?

Russell Jess Giron

What specific Injuries, Damages or Losses did Claimant receive? See attached spreadsheet w/ Letter

(Use back of this form or separate sheet if necessary to answer this question in detail.)

What amount of money is claimant seeking, or if amount is in excess of \$10,000, which is the appropriate court of jurisdiction. Note: If Superior and Municipal Courts are consolidated, you must represent whether it is a "limited civil case" [see Government Code 910(f)]

See attached Lien spreadsheet

(Use back of this form or separate sheet if necessary to answer this question in detail.)

How was this amount calculated (please itemize)? See attached Lien spreadsheet

(Use back of this form or separate sheet if necessary to answer this question in detail.)

Date Signed: 9/12/07 Signature: [Signature]

If signed by Representative: Representative's Name Bernice E. Torrejos Address P.O. Box 45018 Telephone # (800) 442-7247 Ext. 2403 Relationship to Claimant Primary Health Ins. Carrier (TPA)

Re: Our Claimant: Lois Atwell-Miranda
 Date of Injury: March 8, 2007
 Group Name: Tachi Palace Hotel Casino, #355

Count	Claim No.	DOS	Charge Amt.	Paid Amt.	Pending Charges	Notes
1	207-604084-00	6/13/07	62.00	0.00	62.00	<- Amount paid out is subject to change, once claim is processed **
2	207-597671-00	8/15/07	350.00	0.00	350.00	<- Amount paid out is subject to change, once claim is processed **
3	207-506713-00	7/3/07	234.00	0.00	234.00	<- Amount paid out is subject to change, once claim is processed **
4	207-462410-00	7/3/07	2,950.77	0.00	2,950.77	<- Amount paid out is subject to change, once claim is processed **
5	207-460029-00	6/13/07	286.00	0.00	286.00	<- Amount paid out is subject to change, once claim is processed **
6	207-458557-00	6/21/07	113.00	0.00	113.00	<- Amount paid out is subject to change, once claim is processed **
7	207-429820-00	6/13/07	286.00	0.00	286.00	<- Amount paid out is subject to change, once claim is processed **
8	207-309551-00	3/8/07	872.00	0.00	872.00	<- Amount paid out is subject to change, once claim is processed **
9	207-202815-00	3/8/07	185.00	0.00	185.00	<- Amount paid out is subject to change, once claim is processed **
10	207-145587-00	3/8/07	1,270.00	0.00	1,270.00	<- Amount paid out is subject to change, once claim is processed **
			\$6,608.77	\$0.00	\$6,608.77	

** Please contact HealthComp prior to making payment